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Articles

What can a policy do? Challenging the implementation of the More Doctors Program based on the experience of a Brazilian city

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We aim to problematize the implementation of the More Doctors Program based on the experience of a Brazilian city. Using encounter as method, we present affections/reflections emerging from conversations with doctors and other actors involved with the program. The devices for the program operation proved insufficient considering this controversial/conflicting policy. Each municipality implements and takes advantage of the program in its own way, creating or not conjunctures, giving sustainability and potentiating its effects. Adverse situations revealed the fragility of the devices regarding sustainability. The invisibility of the policy and the weaknesses of the devices in the implementation is noted and problematized. The program is an important federal initiative to improve healthcare, especially for the most vulnerable, but it is threatened and weakened after the Cuban doctors' departure. For that reason is key to debate its potentialities and weaknesses.

Keywords: Health consortia. Public health policy. Primary health care. Micropolitics. Delivery of health care.

Introduction

The law nº 12.871[1], of 10/22/2013, created the Mais Médicos (More Doctors) Program (PMM) due to the scenario of a significant shortage of doctors in the country, especially in Primary Care (PC)[2]. The PMM is the largest initiative developed in the country and one of the largest in the world in addressing problems related to three strategic fronts established by this policy: emergency provision of doctors in municipalities with areas of vulnerability; expansion of vacancies and undergraduate courses in medicine; investments in the infrastructure of Basic Health Units (BHU)[1,2].

Given this unprecedented governmental action, investigations have been published presenting policy analyzes from different perspectives: implementation of the program in different locations, effects on the distribution of physicians in the country, on the scope of physicians' practices, health indicators, user satisfaction, among other aspects[3,4], highlighting the evident advances made towards the realization of the right to health[5,6].

Taking into consideration the complex situation presently experienced in Brazil, with the weakening of democracy and the state of imminent loss of rights, it is necessary to problematize this Program under the lens of a public policy. This problematization is complementary to the results obtained from the effects of the PMM in the aspects mentioned, based on the visibilities and possibilities that emerge from the day-to-day of services and management. The establishment of a policy is not given from its text, its intentions and its publication; it is always crossed by disputes, with questions and tensions of different natures about the power of its devices[7].

There is a gap in Brazilian academic production about the multiple ways of implementing and sustaining politics in different realities of the country, considering political and social contexts favorable or contrary to the PMM. Thus, it is necessary that the implementation of the PMM be problematized, analyzing the articulation between the law as an effect and the effects of the law, taking as a research scenario the social and political game of the actors that are involved or are generated in these processes[8]. The objective of this article is to problematize the PMM based on the experience in a Brazilian municipality, putting under analysis the production of power or fragility in the implementation of this policy.

Contextualization

Brazil in 2013 - Broken down gates[e]

We locate as a beginning of this conversation, the social events that occurred in 2013 in Brazil. The volume and variety of social mobilizations allow us to affirm: "the country was literally on fire". The wave of protests that took over Brazil began with demonstrations against the increase in bus fares, and quickly took over the Brazilian territory, spreading to capitals and major municipalities, expanding the target of demonstrations to flags of struggles, containing certain not well-stated prospects on the part of the protesters, with the intention of destabilizing the federal government. These protests erupted whether there was real evidence on some of its accusations or not. They pointed out to corruption in the public and private sectors, lack of public

[e] Expression used by Peter Pál Pelbart when addressing the popular demonstrations in Brazil in the year 2013. Available in: https://drive.google.com/file/d/0B6Dh2r0OH3TickxyRHkwTEZuY1U/view

safety, scrapping of public services, inflationary process, increase in the cost of living and against large amounts of federal government spending to host the 2014 World Cup. They accused those expenditure items as been in detriment of investments in key public policies such as education, health, housing, etc.

There was a strong polarization between political forces in the country. Summoned by social networks, the protests of June 2013 brought thousands of Brazilians to the streets and undermined political stability in Brazil. In the streets, a significant part of the demonstrators who went to the main protests shouted slogans against corruption, against governments and against politicians.

What was behind this scenario? Apparently nothing more than popular dissatisfaction. This was the official version of the mainstream media to "inform" and stimulate protests against a corrupt political system that had produced a society with intense inequalities. Those inequalities, as per the speeches of the mass media, were never associated with the social logic of building for a long time our kind of coarse capitalism in the tropics. It also seemed that a climate of instability was generating, due to the upcoming 2014 presidential election. There was a war in the political narrative and blame charges of the national government, under the command of the Workers' Party, creating a climate of intense polarization between the different social actors, in favor as well as against the continuity of the projects developed by the governments of that political party. Even with the strong opposition movement, President Dilma Roussef was re-elected that year.

As part of the response to the "street voices", recognizing in some of them legitimate issues in their demands, the Federal Government created an agenda of action with several points on more urgent social issues. Within these points of the agenda, it was formulated the legal construction of the PMM.

This Program, among several intentionalities, stated the fundamental objective of bringing physicians to different political-administrative regions of Brazil, that were identified as presenting shortage or absence of these professionals. The Program also included among its actions the opening of new graduate and medical residency vacancies, investments in the construction, remodeling and expansion of BHU's, as well as support and resources for these initiatives to the governments in these places, as well as municipal administrations.

The reality that the population was facing regarding access to health services - and known to many teams that were part of federal, state and municipal governments - was the lack of general practitioners and many specialties in regions of great social and sanitary vulnerability. These regions encompassed small and medium municipalities, and the outskirts of major centers (the complex metropolitan areas), even considering specific policies to incorporate these practitioners in the territorial care networks that the federal government and several states and municipalities already practiced. The Brazilian medical guild, for the most part and in many situations refused to go to those regions. At the same time, the population pointed to the lack of doctors as the main problem of the Unified Health System (SUS)[9].

In 2011 the federal government set as a priority the confrontation of this problem. It regulated the Law 12.202, of January 14, 2010, which allowed doctors who graduated with support from the program of the Student Financing Fund (FIES) to reduce the debt to the Fund, as long as they worked in areas with greater need of

doctors defined by the Ministry of Health (MH)[10]. The shortage of doctors in the country and the important care gaps due to this problem were incorporated by the National Front of Mayors in 2013, through the movement entitled "Where is the doctor?", which brought among the proposals, the flexibility of the entrance of foreign doctors to act in PC[11].

In Brazil, in 2013, the proportion was 1.8 doctors / thousand inhabitants, a proportion inferior to other countries such as Greece-6.1, Cuba-6.0, Spain-4.0, Portugal-3.9, Uruguay-3.7, Bulgaria-3.7, Israel-3.7, Germany-3.6. In addition to the problem of shortage of doctors, there was a problem of unequal distribution of these professionals, as 22 Brazilian states have an index below the national average, and in five of them (all located in the North and Northeast) the proportion is lower than a physician per thousand inhabitants[12], as can be observed in Figure 1.

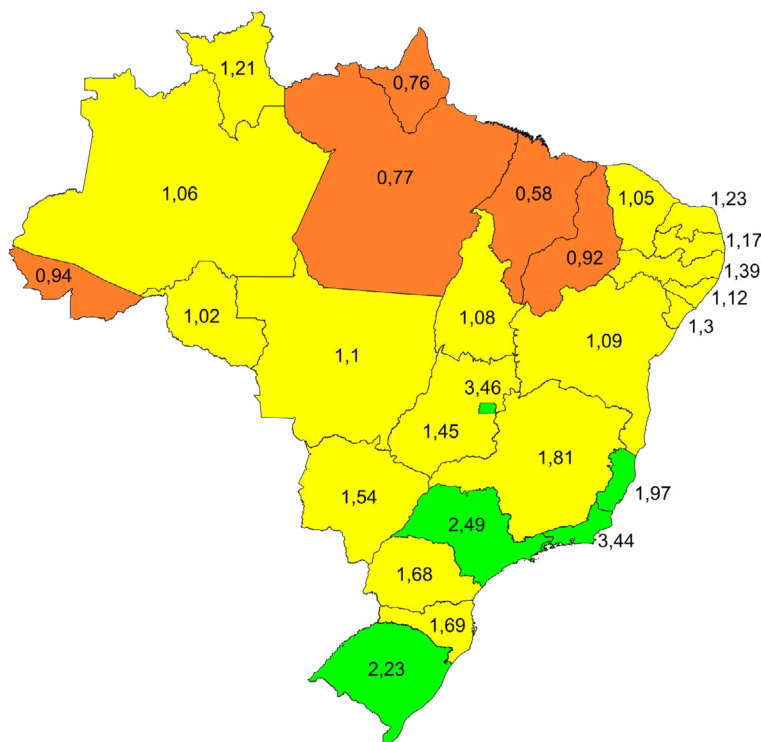

Figure 1. Relation of doctors / 1000 inhabitants per Federative Unit of Brazil (calculations based on IBGE 2012 population data and primary data of the Federal Council of Medicine 2012)[12].

Figure 1 shows the intensity of iniquity related to access to health care with doctors. The geographical distribution of physicians influences the quality of life of the population[13], therefore, any inequality in this distribution tends to generate socially undesirable results and dissatisfaction on the part of the population. However, the major demonstrations against the federal government came from portions of the middle class, as well as in the south and southeast regions of the country, which are usually the who have a greater presence of this professional.

It is important to emphasize that the shortage of doctors in Brazil is not a new or little known problem. It can be said that many Brazilian regions have not seen a PC doctor in many years; with the aggravating circumstance that the presence of specialist doctors is scarce in the specialized or hospital services of these same regions. There is a control in the expansion of the training of specialists by the medical associations, which in many regions are led by groups of specialists with normative capacity over this process, even greater than the governments in the various Brazilian political and administrative spheres.

In the search for a more equitable SUS, strategies had already been tried to face the difficulty of hiring health professionals in vulnerable areas, such as the Countryside Program Health and Sanitation Actions (1976), the Countryside SUS Program (1993), the Countryside Health Work Program (2000), AB-PROVAB Professional Recognition Program (2011), but were not enough to increase doctors retention in those territories[11,14].

As already mentioned, the PMM is part of an extensive project to improve the SUS[15], in the perspective of facing the problem of the shortage of doctors, which had not yet become a social issue or an object of forceful State action, possibly due to the blockade imposed by social forces that maintain the conjuncture[2].

Gomes e Merhy[15] analyzed the political agenda of the main Brazilian national medical entities and their struggles around the PMM of the Ministry of Health of Brazil, and showed that in the last decades there have been important transformations produced by the tensions in the medical work in the SUS, ranging from economic interests related to medicine to micropolitical relations in health work. The most relevant were the change in the pattern of economic accumulation in the sector, which in recent forms of organization of capital in health produced a reversal of the profit relation. It made it better for its expansion that a greater number of people linked to the companies consumes the least possible available services. The insertion of the physicians in the labor market has led to a process of salary without however leading to a proletarianization of this professional or to a total loss of autonomy of this category. Physicians continue to present dimensions of his work that cannot be controlled by the employer, and whose levels of freedom are even consistent with current capitalist interests. The relationships between physicians and other health workers have also undergone transformations, evidencing the dispute over the hegemony of knowledge and health services, since some of the actions that were previously exclusive to the medical category are currently being developed by others professionals. And finally, another factor that causes tension in the sector is the expansion of the offer of undergraduate courses in medicine, which, through the greater supply of professionals in the labor market, may have repercussions in the reduction of the professional group remuneration.

It is at this juncture that the federal government created the PMM with the objective of improving access to health, with the recruitment of 18,240 medical professionals from Brazil and abroad, including professionals who accepted to work in regions that most Brazilian doctors refused. They guaranteed in uncontested access to PC, in 4,058 municipalities (73% of Brazilian municipalities), potentially giving services to 63 million Brazilians[16]. In March 2013, just before the PMM was launched, there were 1,200 municipalities with a shortage of doctors, or 21.6% of the country's

total. In little more than two years of the program this number reduced to 777, to represent 14%. In relation to the total number of physicians in PC, PMM professionals accounted for 12.7%, in 2015[17]. After implementing the program, 700 municipalities located in remote areas of Brazil started to have a doctor in PC with residence in the municipality, an unprecedented fact in history. At that time, Cuban doctors had an exclusive presence in 2,340 municipalities (58% of the Program), and corresponded to 90% of the physicians who worked in Indigenous Health program[16].

The proposal envisaged, in addition to remedying the shortage of doctors in remote regions, the creation of 11,500 new seats in medical graduation courses by 2017, and 12,400 new medical residency vacancies by 2018. By 2013, the country's 27 capitals offered 8,858 places in undergraduate courses in medicine, while all other Brazilian municipalities had 8,612 vacancies. The number of seats in the capitals increased to 10,637 and, in the interior, 14,522. The PMM created 4,742 places of residence across the country. This number should triple by the end of 2017 and universalize by 2019 allowing for each medical graduate a medical residency to be trained as specialist[16].

Even with the significant increase in the number of places in medical graduation and residency programs, advances did not occur as planned during the formulation of the PMM. The processes concerning the opening of new jobs in new and old medical schools and opening new jobs and new residency programs is incomplete. In 2017 the Minister of Education reported that, due to budget constraints, no new places for medical residency would be created in 2018. And the following year the Ministry of Education suspended the opening of new undergraduate medical courses[f].

[f] https://g1.globo.com/educacao/noticia/governo-federal-vai-suspender-a-abertura-de-novos-cursos-de-medicina-diz-mec.ghtml

The PMM is characterized as a policy to address these historical problems accumulated in the SUS. There was tension and resistance on the part of the medical corporation and the Brazilian society as the recruitment of Brazilian and foreign doctors occurred, a resistance that was more evident in relation to Cuban doctors. Even in this context, there were 18,000 physicians for PC, in regions of greater social vulnerability and with difficulty attracting these professionals, producing a significant increase in coverage and access to a re-ordering of the labor market. The present analysis is situated within the immanence of this complex and multifaceted context of formulation and implementation of the PMM.

Method

The research folds

The research group is part of the Network of Observatories for Studies of Public Policies and Health Care that studies public health policies, and initiated the process of investigation in the PMM in a city of Brazil. The research was approved by the Ethics Committee on Research in Human Beings, CAAE: 38804614.8.1001.5291.

Several workshops were held with the participation of several actors, seeking the production of narratives from different oral and written sources, and expanding the possibility of constructing a comprehensive scheme of the effects of the policy and how it was being operationalized.

The Network of Observatories wages its methodological bets in the encounters, and the rest are tools[18]. Under the perspective of the encounter, this article will not objectively address the results of the research, but the affections and reflections

that emerged from the meetings with the PMM physicians, their teams, a group of managers from different areas of the Health Network, users and students of health care.

We started the field from a meeting with the PMM doctors of the municipality, with the participation of 14 doctors: three Cubans, four Brazilians trained abroad and seven doctors trained in Brazil.

As a next step we also met managers from the central level of the municipality, district coordinators and managers of Basic Units of Family Health (BUFH) with PMM doctors. We went to the BUFH where some doctors worked, and we talked to the workers, users and students in training in these services. At each meeting, the invisibility of the PMM in the city studied became more evident, despite the intense disputes and all the resistance that happened around this agenda throughout the country.

Deleuze[19] points to two dimensions of a device, visibility and enunciation. Each device diffuses by distributing the visible and the invisible, by making the object that does not exist without it, to arise or disappear. The PMM device, operates like a machine to allow to see and speak. Visibility makes you “see” and gains shapes, colors and textures. The enunciability does not designate as merely what is talked about the PMM, but what is possible and justifiable to speak of this device. The visibility of which we speak cannot be confused with the palpable forms, with the figures or with the images conveyed by the PMM. Likewise, the utterance does not refer immediately to the sayings, the words uttered or even written in the various discursive planes.

Results and discussion

The doctors of the PMM elaborated narratives that approached diverse subjects. Cuban physicians considered that the difference between a PMM physician and an PC physician was exclusively due to the fact that the PMM physicians remained in the services for 8 hours daily, while the others did not comply with the schedule foreseen: “They attend the patient and leave.” They mentioned the difficulty in expanding the scope of practices in the PC in function of the flows established by the municipality. On the other hand, the Brazilian doctors of the Program do not perceive any difference between being or not of the PMM.

During the meeting with managers of the UBSF, district coordinators, permanent education and workers, they said that they did not have concrete knowledge about the PMM and put innumerable questions about the policy, its objectives, operationalization and places of insertion.

> I do not know how this program works, I’ve never been told anything and I’ve never looked after this. (Speaking of team workers with PMM doctors)

Reinforcing this PMM invisibility image, we talked with students in training at the UBSF, who reported: “We never knew of their existence there or anywhere else in the county.” They also mentioned ignorance of this policy.

> Researchers: “Do you know the PMM?
> Students: “No, we’ve never heard of it.”
> Researchers: “Did you know that in this unit you have a doctor from this program?”
> Students: “We do not know, who is it? What difference does it make to the other doctor? “

Users also reported lack of knowledge about the presence of PMM physicians in the UBSF. In talking with the manager, when addressing the PMM she replied:

> I do not know much about the policy, actually I do not know anything. I just know that they need to take a course, but I do not even know what it is and how it works, I do not know the difference between the PMM doctors and the contractors ... I know Dr. J. is from the program, but I do not know the differences in her work compared to that of Dr. G., who is hired. (Gerente)

In several moments of the research we noticed the invisibility of the PMM and the construction of narratives that did not distinguish the kind of work of the doctors of the PMM and of the other physicians of the PC, either because they did not exist or because they did not know. These findings affected us, which became an intercessor in us[20], leading us to the displacement and de-territorialization as researchers, producing the necessity of searching in our own narratives these affectations, since our regimes of truth and our subjectively marked bodies had other expectations on the production of the narratives of the workers and managers.

In principle, there was an opinion among us that there was a great and evident polarization between support or resistance to the PMM, considering its controversial trajectory of implantation in the broader field of the societal struggle, that occurred in the scope of the relations between professional categories and the formulators of PMM[15]. When we noticed that managers, workers, users and health students were not aware of the PMM, even those with a direct implication in their daily life, that fact run across us as an event[21].

Noting the invisibility of the PMM in the municipality, and the inconvenience caused by this, we were impelled to know the reasons why the municipality joined the PMM. We then talked with the institutional agents who were in the health management of the municipality at the time of the PMM membership, about the reasons for joining the municipality to the program and one of the managers pointed out that it was to meet the needs of doctors in the PC. When asked about the preference of Brazilian doctors to work in the municipality, she reported: “Yes, we prefer Brazilian doctors.”

When asked about the reasons why the management chose preferentially for Brazilian doctors, she states: “Oh, because they’re real doctors.”

What does it mean to say that Brazilian doctors are real doctors? We were building the image of event-effect, facts that were expressed or enunciable by agents that composed the techno-bureaucratic framework of municipal management. For us, they were manifestations that presented themselves as a statement of the desires to manufacture new possibilities and, at the same time, loaded with a great overcoding of

their beliefs regarding the training of the Cuban doctors, incapable to produce "good" doctors. This was the "hidden" message in our conversations.

In the meeting with the coordinator of the PMM of the municipality at the time of the research, the same one reported "The PMM is doing well, I have no problems, I keep track of the presence list and vacations of all of them."

From this observation during the field trials we have several questions: What can a public policy do? Is the PMM's bet limited to the provision of doctors in PC? Does this model of implementation care from the "clock-in list and holiday control"? Is this invisibility intentional or mere effect? Considering the analysis of a public policy, what does the reality found tell us regarding the devices for its implantation and sustentation?

The PMM is a policy formulated and operationalized from the difficult reality found in the municipalities due to the lack of doctors and the incessant demand of mayors and secretaries of health of municipalities of extreme poverty, intense violence, small size and great peripheries. At the same time, there was outstanding resistance, especially from the country's medical guilds, which generated a great controversy and a confrontation with such entities never before seen in Brazil[15]. After President Dilma Roussef was impeached, the government that assumed the federal administration tried to end the PMM, but the approval of society and the resistance of the municipal managers, enabled the policy to remain, however, still under intense attack by the medical guilds and the federal government, who have been opposed to the program.

There is no doubt that the provision of doctors in PC in the country is a necessity, however the sustainability of the policy depends on strong and powerful devices, considering the different realities of Brazil, including the favorable and unfavorable political contexts of the PMM.

The implantation devices of the PMM are the reception to the doctors, support of the supervisors of the Brazilian universities and the offer of courses of specialization, that make possible the performance in the PC of the foreign and Brazilian doctors trained abroad without the Revalida (Licensing Exam), producing a network of protection to the PMM. However, these devices have proved to be insufficient, considering that this policy is controversial, conflicting and noisy.

Each municipality implements and takes advantage of the PMM in its own way, in the municipalities whose scenarios are favorable to the program, they create conjunctures that give sustainability to PMM and potentiate their effects on local health. In unfavorable situations, limited to provision, the narratives revealed evidence of the fragility of devices for their sustainability.

Thinking the same devices throughout the country, regardless of the political context of each place, contributes to weaken the PMM. Differences are not considered, and this arrangement of thinking and operating health policies centrally and hierarchically, from the federal to the local, has been the mark of many teams of different currents of Brazilian public health, whenever they are in a position of government. Within this modus operandi policies are formulated and implemented in a homogeneous and linear way, without considering the specificities in local contexts. Nudging incentives for policies aim to impose standardization, rules and control in order to determine models of care.

In this sense, we emphasize, they operate as if all places and populations are equal, with the same determining characteristics, without taking into account the constitutive differences and distinct political, social, cultural and sanitary contexts in the different regions. This way of doing politics tends to be weak for conducing public policies, especially when it is a policy that mobilizes so different social forces, that tend to position themselves in opposite trenches to dispute it in every detail, generating in what is visible intensification of controversies, wars in narratives and intense disputes for different purposes, such as the PMM.

This way of producing politics, restricted to the formal plane, to the world of rules, rules and ordinances, restricts the production of invention and novelties that consider the specificities of each reality. Creative and inventive management invades formal spaces, produces mobilization and connections for accountability and bonding. It is clear that we have built policies to deal with the problems that the population experiences, and that these policies are always in dispute.

The PMM in the studied city shows the fragility of the devices of sustainability of the policy in adverse political scenarios, as in this situation the power of the policy is emptied. Although the primary demand is the remedial supply of doctors for PC, PMM could in fact strengthen PC. Considering all the confrontation that took place around the program, there is not too much that we gathered from the experience in the municipality studied: just the provision and fulfillment of the working time of the PMM physicians.

The insertion of PMM physicians would be able to impact the production of care insofar as it could be a device to change the way of care in health, which would produce new visibilities from practices different from those instituted and predictable. Producing more of the same in the area of care, operating in the routine, entails invisibility to the policy, without making the best use of the various options that could have been built. A public policy that focuses solely on supply of doctors is not potent, especially when we can aim for and create new visibilities and clarifications about the world of care in PC.

It is necessary to problematize the invisibility of the policy and the weaknesses of the devices, both to implement it and to take advantage of the potentiality in producing the positive effects on health.

Discussing with some sources that produced reflections on the analysis of the implementation of the PMM, it is worth discussing a window of opportunity that opened to change the production of health care throughout Brazil, but also to understand how much and in which way was it permeated by political, judicial, and ideological clashes.

In a scenario where municipal managers were failing to hire doctors to meet PC's demands, particularly in vulnerable regions, the PMM recruitment and placement goals were successful. The call for candidates fulfilled the purpose of immediate hiring, operating with decentralized management, well-defined roles and clear and organized hiring process. The PMM produced the possibility of facing problems that until then were exclusively faced by the municipal management teams in the provision of quality health care.

Considering all the complexity and multiple crossings for the implementation of PMM throughout the national territory, there is evidence of positive effects on

different health indicators, which should be mentioned briefly. Several sources indicate that PMM has created opportunities to change the production of health care throughout the country.

There is evidence that in a short period of time the PMM provided important results, such as: increased PC coverage at a volume and speed significantly higher than previous years; expanded access to PC actions; diversified the scope of procedures in PC; increased the rate of reduction of PC-sensitive hospitalizations; was an important alternative for Brazilian physicians; it had good evaluations by users, physicians and managers[6]; increased the number of consultations, high degree of satisfaction of users regarding the waiting time to schedule appointments, as well as with the attendance during the consultation[17], fulfilled medical gaps, equity in distribution in areas of greater vulnerability, and physician need[6,17,22], reduced physician turnover in PC[23]. In addition to the provision, the PMM promoted the expansion of the number of vacancies in undergraduate and residency in medicine and mobilized financial resources for the improvement of the infrastructure of the UBS[24]. It is important to point out that, even with the important positive results, there was resistance from some professionals about the actions of Cuban doctors[22].

The evidence presented shows the positive impacts of PMM on the health of the population, despite the fragility of its implementation devices. These results were never achieved with strategies previously employed to address the problem of providing physicians in vulnerable Brazilian areas, and in a short period of time. Still, resistance movements to the program persist, especially in relation to Cuban doctors. The opposition to the actions of Cuban doctors in the PMM got even more prominent from the statements of the president-elect of Brazil in 2018, who would expel Cuban doctors from the country[(g)]: "We have no evidence that they are doctors themselves and that they are trained to practice." Another statement by the president-elect who finds echo in part of society and medical institutions is that "around 70% of the salary is confiscated by the Cuban dictatorship"[(h)].

Even as the PMM was legitimized by the Federal Supreme Court in 2017[(i)], the president-elect imposed conditions for the continuity of the cooperation agreement between Brazil and Cuba: in order to participate in the Program, the physicians should be approved in the licensing exam Revalida, and no percentage of doctors' salaries would be passed on to the Cuban government[(j)]. Under these conditions, associated with the questioning of the veracity about the medical training of the foreign doctors, in November 2018 the Cuban government informs the decision to exit the PMM[(k)].

It is in this context that the PMM has intensely reduced its medical staff in a single stroke. At the end of 2018, of the 16,707 professionals in the Program, more than half were Cubans, responsible for the health of more than 28 million Brazilians in 2,857 municipalities[(l)]. Cuban doctors worked in the most vulnerable areas of the country: North, semi-arid region of the Northeast, cities with low HDI, indigenous health, peripheries of large urban centers. PMM physicians were only Cuban in 1,575 municipalities, of whom 80% are small cities (less than 20 thousand inhabitants) as well as located in vulnerable regions. Three hundred Cuban doctors worked in indigenous villages, corresponding to 75% of the doctors working in the Indigenous Health System of the country. A significant contingent of Brazilians - those most in need and living in the most vulnerable regions - will suffer the most[(m)].

[(g)] https://g1.globo.com/sp/presidente-prudente-regiao/noticia/2018/08/22/bolsonaro-diz-que-vai-usar-revalida-para-expulsar-medicos-cubanos-do-brasil.ghtml

[(h)] https://www.terra.com.br/noticias/mundo/mais-medicos-o-que-disseram-cuba-e-bolsonaro-sobre-a-saida-dos-cubanos-do-programa,afe6186bb0caa05b82af5e83c587bff5yddsjloa.html

[(i)] https://g1.globo.com/politica/noticia/por-maioria-stf-valida-regras-do-programa-mais-medicos.ghtml

[(j)] https://g1.globo.com/mundo/noticia/2018/11/14/cuba-decide-deixar-programa-mais-medicos-no-brasil.ghtml

[(k)] http://www.granma.cu/cuba/2018-11-14/declaracion-del-ministerio-de-salud-publica-14-11-2018-09-11-05

[(l)] https://g1.globo.com/politica/noticia/2018/11/15/saida-de-cuba-do-mais-medicos-afeta-28-milhoes-de-pessoas-diz-confederacao-dos-municipios.ghtml

[(m)] http://www.redeunida.org.br/pt-br/comunicacao/news/rede-unida-se-manifesta-sobre-continuidade-do-prog/

Final considerations

The PMM is an important federal initiative that intends to provide SUS users with increased and improved health care, especially for the most vulnerable population. The challenge to date consisted in the visibility of possible benefits for health care; however, with the withdrawal of the Cubans from the PMM, the provision of doctors in the most needy, distant and vulnerable regions is compromised, as is also compromised the sustainability of the policy due to the important resistance of the group that assumed office in Brazil from 2019 on. The policy is threatened and, for that, discussing the potentialities and fragilities of the PMM is key.

The problematization presented here does not have the pretension of generalization, nor of questioning or comparing to other results of studies that approach the PMM in different aspects. The present text proposes a discussion about the complex and multifaceted reality of the formulation and implementation of the PMM policy, in which both common aspects are identified under apparent homogeneity as well as, in a not always visible way, other views of the point regarding the PMM.

We rely on the power of the production of ways to manifest visibilities and utterabilities that are intertwined in particular historical, ethical and political contexts within the scope of the analysis of the public policies of health and care, but we should not fail to emphasize how much the power of a device such as PMM has been reduced in producing new ways of caring beyond medical practices focused on procedures, rather than on comprehensive health care.

Authors' contributions

The author Mara Lisiane de Moraes dos Santos participated in the conception and design of the work, of the discussion of the results; writing of the manuscript, critical review of content and approval of the final version of the manuscript. The author Débora Cristina Bertussi participated in the discussion of the results, drafting of the manuscript, critical review of content and approval of the final version of the manuscript. The author Vera Lúcia Kodjaoglanian Santos participated in the conception and design of the work, participation of the discussion of the results; writing of the manuscript and approval of the final version of the manuscript. The author Emerson Elias Merhy participated in the conception and design of the work, of the discussion of the results; critical revision of the contents and approval of the final version of the manuscript.

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